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Obsessive compulsive disorder and obsessive compulsive personality disorder and the criminal law

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Obsessive compulsive disorder (OCD) is a mental illness that has penetrated public consciousness. However, the extent to which OCD and obsessive compulsive personality disorder (OCPD) can constitute debilitating conditions that adversely affect most aspects of a person's functioning and quality of life are not so well known, including as to how they can impair the capacity to give reasoned consideration to conduct options and the consequences of choices. Little scholarship exists about the legal repercussions of OCD and OCPD and, in particular, their potential relevance for both assessments of criminal responsibility and criminal culpability. This article commences to redress that deficit, outlining contemporary clinical knowledge about the disorders that is relevant to the legal context and identifying important judgments by courts in the United Kingdom, Ireland, Canada, Australia, New Zealand and India which have dealt with the potential impact of OCD and OCPD, in particular for decisions at the sentencing phase of criminal proceedings. It calls for better awareness of OCD and OCPD on the part of forensic mental health practitioners, criminal law practitioners and members of the judiciary.

Key words: autism spectrum disorder; criminal culpability; obsessive compulsive disorder; obsessive compulsive personality disorder; sentencing.

> Countless times, I have endured severe depression, suicidal thoughts, debilitating anxiety, recurring feelings of lacking self-worth or self-esteem, a proclivity for physical violence, a disdain for authority, the loss of employment and a general malaise regarding my purpose in life. While also experiencing exhilarating highs and personal successes, I have felt possessed by the devil. Wherever you have visited in your own mind, I have been there or close by. For decades I constantly searched for different medications and more effective therapies to control my OCD, all in vain. … No psychiatrist, no psychologist, no parent or family member, no human being who doesn't suffer from OCD, can realistically understand the insidiousness, the intensity or level of debilitation the disorder brings.
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> James S Julian, *A Secret Life* (2019), p 9, 163

Introduction

Obsessive compulsive disorder (OCD) is a stigmatising neuropsychiatric disorder characterised by recurrent and intrusive distressing thoughts and repetitive behaviours or rituals performed to reduce anxiety. It is frequently comorbid with other psychiatric disorders, especially anxiety and depression.[1] OCD has the potential to exercise an adverse impact

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upon some or all areas of a person's life, including education, employment, career development, relationships with partners, parents, siblings and friends, starting a family, access to own children and quality of life generally.[2] OCD can be characterised by relentless ideas, impulses and images and is associated with substantial interference with daily quality of life (QOL)[3] and functional impairment,[4] especially in the context of comorbid depression and anxiety.[5]

A cross-sectional assessment of caregivers to patients with OCD found that age of patient, longer duration of illness and longer duration of treatment were predictive of poorer QOL of caregivers in the physical health domain. Greater objective burden, disruption of family leisure and interaction due to OCD led to significantly poorer QOL in all domains for caregivers.[6] In the World Health Organization's 2017 report, *Depression and Other Common Mental Disorders: Global Health Estimates*, OCD was included amongst anxiety disorders which were listed as the sixth largest contributor to non-fatal health loss worldwide.[7]

Symptoms are often accompanied by feelings of shame, embarrassment and secrecy which, in turn, contribute to both under-diagnosis and delayed diagnosis. This is in spite of the condition being part of popular parlance and community consciousness. It has been depicted in the 1997 Jack Nicholson movie *As Good As It Gets* and in the television series *Monk*. There are self-report inventories for the condition (see, eg, Obsessive-Compulsive Inventory–Revised[8] and the Florida Obsessive-Compulsive Inventory[9]), and multiple personal accounts of living with OCD have been published.[10] However, it shares features in common with a number of other psychiatric disorders, raising the potential for misdiagnosis and under-diagnosis.[11]

This article reviews the current state of clinical knowledge about OCD and obsessive-compulsive personality disorder (OCPD). While there are judgments that have referred to victims of crime having OCD, including in conjunction with post-traumatic stress disorder,[12] this article focuses upon offenders with OCD. The relationship of OCD with criminal offending is a topic that has been little written about save in occasional anecdotal accounts.[13] This article begins to redress that deficit. It identifies significant decisions in the United Kingdom, Ireland, Canada, India, Australia and New Zealand in which OCD and OCPD have figured in criminal trials and at sentencing. It calls for better awareness of both conditions by forensic mental health clinicians who undertake work as expert report-writers and witnesses, litigation lawyers and members of the judiciary so that better-informed evaluations of criminal culpability and likely recidivism can be made.

Diagnostic criteria for OCD and OCPD

Under the 2013 *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), OCD was newly categorised.[14] It has the following diagnostic criteria:

A. Presence of obsessions, compulsions or both:
   Obsessions are defined by (1) and (2):

   1. Recurring and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
   2. The individual attempts to ignore or suppress such thoughts, urges or images, or to neutralize them with some other thought or action (ie by performing a compulsion).

   Compulsions are defined by (1) and (2):

   1. Repetitive behaviors (eg hand washing, ordering, checking) or mental acts (eg praying, counting,

repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (eg take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (eg a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder.

Those with OCD show varying degrees of insight into the validity of their obsessions and compulsions – 'some acknowledge that their obsessions are unrealistic, while others are more firmly convinced (approaching delusional intensity) that the symptoms are rational'.[15] To accommodate this parameter of OCD, it is orthodox for diagnosticians to specify whether the person with OCD has good or fair insight, poor insight or no insight or has delusional beliefs.

DSM-5 includes a specifier to distinguish between people with and without tic-like symptoms. Those with OCD who have tic symptoms can be difficult to distinguish from those with Tourette's disorder. The principal distinction is that, for those with Tourette's disorder, tics are spontaneous acts evoked by a sensory urge, while compulsions in OCD are deliberate acts evoked by affective distress and the urge to reduce fear.[16]

Classic categories of obsessions are:

- aggressive obsessions;
- sexual obsessions;
- contamination obsessions;
- religious obsessions;
- obsessions of harm, danger, loss or embarrassment;
- superstitious or magical obsessions;
- perfectionistic obsessions; somatic obsessions;
- neutral obsessions and symmetry/ordering obsessions; and
- 'just right' feelings.[17]

Compulsions have been grouped into several categories, including:

- frequent washing and cleaning;
- checking more than is necessary;
- repeating specific phrases or redoing certain routine actions;
- counting compulsions;
- arranging and ordering things such that they are straight, sequenced or in a certain order; and
- Needing to ask, tell or confess.[18]

OCD has a one-year prevalence of 1.2% and a lifetime prevalence of 2.3% in the adult population. It affects women slightly more than men, and women who are pregnant or in the postpartum period have been found to be 1.5 to 2 times more likely to experience OCD compared with the general female population.[19] Males have been identified as constituting the majority of early-onset cases, with nearly a quarter of males having onset before age 10. By contrast, females have been found to have a much more rapid accumulation of

new cases after age 10, with the highest slope during adolescence. There are few new onsets among males or females after their early 30s.[20]

However, OCD is a highly heterogeneous condition; different persons diagnosed with OCD can have very different and non-overlapping symptom patterns, as well as varying significantly in intensity of symptomatology.[21]

The United States National Comorbidity Survey Replication study reported that more than a quarter of subjects who were evaluated developed obsessions and compulsions at some point in their life and possibly manifested with a full OCD.[22] The most common age of onset is reported to be between 22 and 35,[23] while affected patients have been reported as spending an average of between 11 and 17 years before receiving treatment after meeting diagnostic criteria.[24] It is an illness that is highly stigmatised and can result in significant discrimination. About 8% of first-degree relatives have OCD.[25] It has been suggested too that there is a significantly escalated rate of suicidality amongst those with OCD.[26]

In addition, those with OCD have a variety of hypotheses concerning why they developed their condition. The overarching finding of a 2019 Scandinavian study was that many of the participants regarded OCD as a coping strategy whereby the rituals served as a way to manage different types of situations which, in turn, were characterised by a need to control chaos, uncertainty and a feeling of helplessness, taboos, limited opportunity to talk about negative emotions and fear of anger and punishment from close relatives. Another potential cause linked to the development of OCD identified by some participants was family heritage.[27]

Unsurprisingly, Obsessive-compulsive personality disorder ('OCPD'), termed anankastic personality disorder by ICD-10, has related criteria:

> A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
>
> 1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of activity is lost.
> 2. Shows perfectionism that interferes with task completion (eg is unable to complete a project because his or her own overly strict standards are not met).
> 3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).
> 4. Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
> 5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.
> 6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
> 7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
> 8. Shows rigidity and stubbornness.

For those with OCPD the pursuit of perfection is problematic in a variety of ways.[28]

The DSM-5 makes the point that:

> Despite the similarity in names, OCD is usually easily distinguished from obsessive-compulsive personality disorder by the presence of true obsessions and compulsions in OCD. When criteria for both obsessive-compulsive personality disorder and OCD are met, both diagnoses should be recorded.[29]

The parameters and definition of OCPD remain controversial.[30] The prevalence of OCPD is estimated at between 2.1% and 7.9% of the general population but due to the intransigent nature of the disorder, and the fact that it can be self-managed, it may well be that such figures are significantly under-reported.

Diagnostic history and prominent persons diagnosed with OCD

In the nineteenth century, Esquirol (1772–1840) wrote of 'reasoning monomania', a form of insanity, in ways that overlap with modern concepualisations of OCD, oscillating in attributing it to disordered intellect and disordered will,[31] and in 1875, Henri Legrand du Saulle described a specific neurosis in which his patients were plagued by anxiety. He referred to it as 'la folie du doute avec délire du toucher'.[32] One of his patients was a 12-year-old girl who believed that all the objects in her home were impregnated and covered with cancerous matter because a person with a facial cancer had visited her house. She recognised that her terrors had no basis but she could not banish them from her mind.

The German psychiatrist Griesenger wrote up three cases of what he termed 'Grubelnsucht', a ruminatory or questioning illness. Westphal described it as 'Zwangsvorstellung' (compelled presentation or idea), which in due course was translated in Great Britain as 'obsession' and in the United States as 'compulsion'.[33]

Freud described what he termed 'obsessional neurosis', with symptoms of what today we term obsessions. In his 'Notes upon a Case of Obsessional Neurosis' in 1909, he wrote of Ernst Lanzer, 'the Rat Man' who presented to him with a number of distressing obsessions – principally a fear of corporal punishment from his father and a female friend using rats.[34] Lanzer would then stare at his penis, sometimes using a mirror. His fear had grown out of an account he heard from a fellow army officer concerning a Chinese torture method in which a large pot, containing a live rat, was strapped to the buttocks of the victim, and the rat was encouraged by a red-hot poker to gnaw its way out through the victim's anus. Lanzer claimed that he fantasised about murder and suicide and developed a number of compulsive irrational behaviour patterns. For example, he mentioned his habit of opening the door to his flat between midnight and 1:00 am, apparently so that his father's ghost could enter. Freud believed that his patient's fears had their origin in sexual experiences during his infancy, in particular harsh punishment for childhood masturbation and sexual curiosity: 'The story of the rat punishment, as was shown by the patient's own account of the matter and by his facial expression as he repeated the story to me, had fanned into a flame all his prematurely suppressed impulses of cruelty, egoistic and sexual alike'.[35] Freud claimed to have cured him using psychoanalysis.

Many high-profile persons have been retrospectively diagnosed with OCD.[36] An example is the scholar Robert Burton, who wrote in his 1621 *Anatomy of Melancholy*, 'If he be in a silent auditory, as at a sermon, he is afraid he shall speak aloud and unaware, something indecent, unfit to be said'.[37] Obsessions and compulsions were often described as symptoms of religious melancholy. The Bishop of Norwich, John Moore, spoke of the problem, describing worshippers obsessed by 'naughty and Blasphemous Thoughts [which] start in their Minds, while they are exercised in the Worship of God [despite] all their endeavors to stifle and suppress them. … [T]he more they struggle with them, the more they increase'. In this regard John Bunyan wrote that his impulses to speak blasphemies were so strong 'that often I have been ready to clap my hand under my chin, to hold my mouth from opening'.[38] Friends and colleagues of Samuel Johnson observed that when he walked along the street, he never stepped on cracks and touched every post as he passed it and, if he missed one, he felt

obliged to return to touch it, while his friends waited for him. James Boswell, his biographer, recorded that:

> He had another peculiarity, of which none of his friends even ventured to ask an explanation. It appeared to me some superstitious habit, which he had contracted early, and from which he had never called upon his reason to disentangle himself. This was his anxious care to go out or in at a door or passage, or at least so that either his right or his left foot (I am not certain which), should constantly make the first actual movement when he came close to the door or passage.[39]

Today we might view Johnson's condition as a subset of OCD. Specifically his 'scrupulosity' focused upon obsessive religious doubts and fears, blasphemous thoughts and images, as well as compulsive religious rituals, reassurance-taking and avoidance.[40] Such symptoms can overlap with other forms of OCD, such as contamination, an aspect of OCD said to be on the rise in the age of COVID-19.[41] It has been claimed to be particularly prominent amongst patients whose primary symptoms involve unacceptable obsessional thoughts, such as about sex and violence, and may be particularly associated with increased depressive and anxious symptoms.[42]

Raymond Fowler undertook a psychological autopsy of the billionaire Howard Hughes, who died in 1976 amidst terrible consequences of what under DSM-5 is classified as hoarding disorder.[43] He concluded that, amongst other things, Hughes suffered from progressively worsening OCD. He reported that:

> He made people who worked with him carry out elaborate hand-washing rituals and wear white cotton gloves, sometimes several pairs, when handling documents he would later touch. Newspaper had to be brought to him in stacks of three so he could slide the middle, and presumably least contaminated, copy out by grasping it with Kleenex. To escape contamination by dust, he ordered that masking tape be put around the doors and windows of his cars and houses.[44]

These aspects of OCD highlight the fact that a range of legal ramifications have the potential to flow for those who experience high levels of symptomatology, including potentially coerced treatment and even guardianship orders. For those whose compulsive behaviours find expression in hoarding, other public health measures may become necessary.

Diagnostic issues

OCD is highly heterogeneous but for those with pronounced symptomatology very difficult to live with.[45] It has high rates of comorbidity[46] with conditions such as attention-deficit hyperactivity disorder ('ADHD'),[47] Asperger's disorder/autism,[48] Tourette's disorder,[49] oppositional defiant disorder and especially depression and anxiety. In a 2010 analysis it was found that 90% of respondents with lifetime DSM-IV/CIDI OCD met criteria for another lifetime DSM-IV/CIDI disorder. The most common comorbid conditions were anxiety disorders (75.8%), followed by mood disorders (63.3%), impulse-control disorders (55.9%) and substance use disorders (38.6%).

This extent of OCD comorbidity has led Accordino et al to observe that 'it is crucial that clinicians assessing individuals presenting with OCD-relevant behaviour be equipped with a strong knowledge of the clinical correlates of ASD and potential overlap with OCD'.[50] They made the important point though that:

> Individuals with ASD and OCD are likely to differ in how they perceive or experience repetitive thoughts (circumscribed interests in ASD, obsessions in OCD) and repetitive behaviors (stereotypies and rituals in ASD, compulsions in OCD). The circumscribed interests seen in individuals with ASD are qualitatively different from

> the obsessions present in those with OCD. Although both involve abnormally intense and time-consuming thoughts of a particular topic, preoccupations seen in ASD are generally ego-syntonic, and experienced as self-generated interests that the individual preferentially focuses on and takes significant pleasure in pursuing. … The obsessions of adolescents and adults with OCD, on the other hand, are neither pleasurable nor experienced as voluntary. They are intrusive and unwanted thoughts that cause marked distress or anxiety (ego-dystonic).[51]

Similar distinctions arise in relation to perceptions of repetitive behaviours, with many with symptomatology of ASD identifying the desirability of such behaviours, while most with OCD experience them as uncontrollable and unpleasant.

Aetiologies of OCD

A number of theories have been advanced to explain the development of OCD. There are biological theories which can be divided into neurotransmitter and neuroanatomical theories.[52] The former suggest that abnormalities in the serotonin system, particularly the hypersensitivity of postsynaptic serotonergic receptors, are responsible for the symptoms. The latter suggest that obsessions and compulsions arise from structural and functional abnormalities in the orbitofrontal-subcortical circuits which are thought to connect regions of the brain involved in processing information with those involved in the initiation of certain behavioural responses. Overactivity is theorised as leading to OCD.[53]

Alternatively, there are traumatic conditioning theories that early learning traumas can affect responses and thereby create behaviours directed toward extinguishing the fear. There is a significant co-occurrence of OCD and PTSD, and patients with OCD frequently report significant and traumatic life events prior to the commencement of OCD symptomatology.[54] This has been particularly evidenced in war veterans' reports[55] and suggests the potential for trauma to be an inadequately recognised precipitant to the development of OCD. Significantly, a 2011 Chinese study[56] found that OCD patients showed a significantly greater severity in all four types of trauma when compared with controls: 77% of OCD patients reported at least one type of childhood trauma experience, and 18% reported sexual trauma. The authors commented: 'Sexual trauma experience is significantly associated with obsessive but not compulsive symptoms of OCD patients. When compared to female OCD patients, male patients reported significantly higher scores on general trauma, physical abuse and emotional abuse; but lower of sexual abuse'. Avoidance and rituals can be negatively reinforced by the reduction in discomfort that they engender and thus evolve into strong habits.

Another theory in relation to the aetiology of OCD is in relation to potential deficits in neuropsychological and information-processing functions.

However, there is also evidence that the experience of trauma can play a role either in OCD coming into existence or in its becoming symptomatic or more symptomatic. This issue has been litigated in civil trials. For instance in *Wall v Phan*,[57] Oliver J of the Supreme Court of British Columbia was called upon to decide the causation of symptoms in a plaintiff as a result of a motor vehicle collision on an icy road. Her pre-existing asymptomatic osteoarthritis was aggravated and she became anxious and depressed and developed obsessive fears regarding dirt and contamination which caused her to clean her house compulsively and with ever-increasing frequency. Oliver J concluded that:

> Obsessive compulsive disorder is principally a biological disorder with a strong genetic component. Stress may be a factor in the development of obsessive compulsive disorder in those who are already heavily predisposed by such biological factors. Undoubtedly the motor vehicle accident was stressful, though not

> in my view of sufficient gravity to cause obsessive compulsive disorder standing alone. (at [25])

This led him to attribute 35% of the plaintiff's psychological injuries to the motor vehicle accident.

Treatments for OCD

A 2013 epidemiological study suggested that approximately 50% of those with OCD reach sustained remission by the age of 50 years.[58] There are two mainstream forms of treatment for persons with OCD. The first is cognitive behavioural therapy,[59] especially exposure response prevention therapy (ERP therapy).[60] Such treatment has two principal components:

1. Direct or imagined, controlled exposure to situations, objects, or other triggers of the patient's obsessive thoughts that create anxiety; and
2. prevention of the patient from engaging in any rituals aimed at reducing the anxiety caused by the exposure.

A meta-analysis found that approximately two-thirds of patients who received ERP experienced symptomatology improvement and approximately one-third recovered.[61] The second form of treatment is pharmacological – the use of the tricyclic antidepressant clomipramine (Anafranil)[62] and selective serotonin reuptake inhibitors (SSRIs), fluoxetine (Prozac), fluvoxamine (Luvox), sertraline, (Zoloft), paroxetine (Paxil), citalopram (Cipramil) and escitalopram (Lexapro). However, treatment response is often incomplete and it is common for some symptoms to remain. In addition, some OCD is also SSRI-resistant.[63] A combination of both forms of treatment is the preferred treatment approach, at least in persons with severe OCD.[64]

The National Institute for Health and Clinical Excellence (NICE) urges in its guidelines on OCD that:

> If healthcare professionals are uncertain about the risks associated with intrusive sexual, aggressive or death-related thoughts reported by people with OCD, they should consult mental health professionals with specific expertise in the assessment and management of OCDS. These themes are common in people with OCD at an early age, and are often misinterpreted as indicating risk.[65]

False confessions

Some forms of OCD can involve intense concerns about causing harm to others – physical harm to children, pushing people where they are vulnerable and engaging in inappropriate forms of sexual behaviour.[66] One form of this has been described as 'pedophile OCD', where a person is not pedophilic but becomes obsessed with concern that they are and that they might behave inappropriately toward children.[67] In turn this can result in their providing a false confession or false admissions in response to questioning by authority figures. Similarly, there is sexual orientation OCD,[68] formerly often termed homosexual OCD or H-OCD[69] which can result in pathological obsessionally about sexual orientation and potential conduct arising from the putative orientation.

Defence and sentencing issues

It would be rare for an OCD or OCPD to be such as to provide to an offender a full criminal defence. Potentially though it could afford a partial defence for murder.

An example of where such a defence was advanced is recorded in the decision of Beech-Jones J of the New South Wales Supreme Court in *R v Quinn (No 2)*,[70] a case involving the stabbing murder of his girlfriend by an offender with OCD and borderline personality disorder (BPD). Quinn formed the view that his girlfriend was cheating on him. He had a history of self-harm in the aftermath of having been sexually abused at the age of 12 and of compulsive behaviour. A forensic psychiatrist, Dr Olav Nielssen, described the mechanism

by which Quinn's capacity to control his actions was substantially impaired as follows:

> His combination of disorders are likely to have had a significant effect on his ability to control his actions. His severe mood swings producing states of severe depression and also anger, and also the impairment in impulse control that goes with Obsessive Compulsive Disorder in those situations, between the combination of the two are likely to have significantly affected his capacity for selfcontrol. …
>
> There's extreme sudden mood swings with irrational anger and severe depression that can be triggered by small events and appear completely disproportionate and so it is a loss of emotional control.[71]

However, Beech-Jones J was not satisfied that Quinn's OCD (or BPD) substantially impaired his capacity to understand events, to judge whether his actions were right or wrong or his capacity to control himself. Thus, he found him not to qualify for the partial defence of substantial impairment by abnormality of mind provided for by s 23A of the *Crimes Act 1900* (NSW).

More commonly it is contended at sentencing that an offender's moral culpability is lessened by reason of their having OCD or OCPD. On occasion it has been contended that the mere existence of OCD or OCPD in an offender constitutes a mitigating consideration, meaning that a less serious sentencing order should be made. As the New Zealand Court of Appeal pithily summarised in *French v The Queen* though:[72]

> A mental disorder falling short of exculpating insanity may be capable of mitigating a sentence either because: if causative of the offending, it moderates the culpability; it renders less appropriate or more subjectively punitive a sentence of imprisonment; or because of a combination of those reasons. The moderation of culpability follows from the principle that any general criminal liability is founded on conduct performed rationally by one who exercises a willed choice to offend.

However, on multiple occasions the fact that a person has a mental disorder automatically constitutes a significant mitigating factor, reducing an offender's blameworthiness, has been rejected. More is necessary in terms of establishing the relevance of a disorder for sentencing than merely adducing evidence that the defendant experienced symptomatology of any mental disorder, including OCD or OCPD. As Duffy J of the New Zealand High Court commented in *Denden v Police*:[73]

> The starting point is to identify the gravity of the offending. … Drink driving is a serious offence. … Mr Denden submits that the culpability should be reduced by reference to his medical condition. He argues that his obsessive compulsive disorder and being on medication, in combination with alcohol, 'is at the heart of this incident'. But he has not led any evidence that shows that the medical condition lowered his culpability or impacted on his offending. So I reject this submission. There is no evidence to suggest that his obsessive compulsive disorder led him to drive after drinking more than a small amount. It did not lead him to flee the police.

To a similar effect Randerson, Keane and MacKenzie JJ of the New Zealand Court of Appeal, dealing with an appeal against a sentence of five-and-a-half years' imprisonment imposed on a woman with OCD who had been found guilty of arson of her house after lighting a fire outside her sons' bedroom, concluded:

> The appellant's actions are so inconsistent with a parent's natural concern to protect his or her children that we must consider carefully whether this may be a consequence of a mental illness short of insanity which may be seen as reducing her culpability. We do not find in the reports significant support for the fact that the appellant's mental condition may be causative of the offending in a way which

> moderates the culpability of that offending. … There is no sufficient basis to conclude that the disturbed thought processes which have culminated in this offending are the result of impaired mental functioning through psychiatric or psychological disorder. The sentencing Judge, who had ample opportunity to observe the appellant, did not think that was the case. He considered that she had set up unnecessary concerns in the minds of the children that their father meant to cause them harm, and that she was disconnected from reality. He described her as having fashioned an evil plan to deprive her husband of an entitlement. There is no basis upon which we could properly conclude that the culpability of the offending is moderated by mental health issues.[74]

If suitable mental health expert evidence is adduced, there is the potential for OCPD to be regarded to some degree as a mitigating factor at sentence. In *R v Tait*,[75] Priestley J of the New Zealand High Court had cause to sentence Tait for the murder of his elderly father with a hammer. The attack was ferocious and found to have been inflicted with a degree of rage. A psychiatric report expressed the view that Tait had suffered from deteriorating and untreated OCPD of the parsimonious compulsive type. Priestley J concluded that the OCPD accounted for Tait's tendencies to hoard, to be reclusive, to be somewhat suspicious and to resent what he saw as intrusions into his life and space. Tait's parents tried unsuccessfully over a number of years to engage assistance from mental health facilities for their son. They were advised to attempt to get Tait to shoulder more domestic responsibility and to cut down on the availability in the kitchen of his favourite foods; however, this, 'far from assisting your OCPD, led to a marked decline as was apparent from the evidence in your trial of you becoming more angry and jostling your parents. Your father, who clearly was growing tired of the limitations and expense of your continued occupation of his home, was the primary target of your irritation'. Priestley JA concluded that OCPD was an important driver of Tait's offending, and that without it, or if the disorder had been treated, it was improbable that Tait would have reacted with the violence which he did towards his father when he saw him as crossing him. He sentenced Tait to life imprisonment with a minimum 10-years' imprisonment to be served. The reasons for sentence constitute something of a high watermark in relation to the sentencing relevance of OCD.

Violence

On some occasions people with OCD can be criminally violent. There can be a number of reasons. One is because of distress suffered when another person inadvertently or deliberately disrupts or tries to interrupt an obsession or is perceived to break rules without justification. It has been observed too that:

> The secondary risk is that individuals can become violent or intimidating towards family members or health professionals (e.g. if someone 'contaminates' a clean object or says a word that is avoided, a person with OCD can feel extremely threatened). This is particularly likely to occur in children or adolescents because there is commonly a very high level of family involvement in rituals, which can lead to a great deal of frustration and anger in the home.[76]

In addition, a person with OCD may be outraged and distressed when they perceive that another is wronged and take inappropriately physical action to protect them, resulting in their being charged with offences of violence. An example of this is a bail appeal heard by the Kerala High Court in India.[77] It was asserted that the applicant rushed towards a man and abused him profusely after the man had parked his vehicle adjacent to the house of his wife. When the wife intervened in the fracas, it was alleged that the applicant pushed her and assaulted her before attacking her husband with a solid block and fracturing his right orbital bone. However, information provided

to the court established that the applicant had a severe form of OCD. The applicant's parents had objected to the parking of the vehicle, and, 'under the impression that the life of his parents [was] in danger, he was thrust into panic mode', following which were his problematic interactions with the driver and his wife.[78] On this basis he was granted bail on stringent conditions.

Another group vulnerable to angry or violent outbursts are people with OCD in the context of the comorbidity of autism spectrum disorder, especially when they customarily adhere to rigid routines from which they cannot easily vary. Such individuals commonly have a poor understanding of their own and others' mental states (Baron-Cohen, 2001); they may therefore have difficulty in empathising with the effect of their compulsions on others, may be unable to explain what they are experiencing or may be unable to deal with the situation by expressing emotions conventionally/appropriately. In such cases, the individual is not acting on their compulsion or avoidance in their usual way. Substance misuse can increase this impulsivity.

Persons with both OCD and OCPD can have impaired impulse control in relation to their conduct and reduced ability to focus on the likely consequences of their conduct. An illustrative case in this regard is that of *R v D'Aloisio*,[79] where the accused assaulted his 6-week-old child, causing him fatal injuries. He suffered from both OCD and OCPD, as well as from depression. Eames JA of the Victorian Supreme Court in Australia emphasised that while the disorders were relevant, 'Your mental illness, however, is not the whole explanation for your conduct'.[80] Professor Kyrios, a psychologist and expert in OCD, asserted:

> Mr D'Aloisio's highly developed need for control, particularly with respect to control of emotional expression, led to chronic internalising of negative emotions. In the context of mounting stress, this situation is tantamount to a balloon ready to burst. There is a clear link between Mr D'Aloisio's personality make up and subsequent mood problems (e.g. depression, agitation, anger). There is also a clear link between his mental health problems and poor decision making, low coping capacity, and intolerance for situations he could not control. It is my opinion that Mr D'Aloisio's obsessional personality and mental health problems were at the centre of his response to his temperamentally demanding baby. At the time he was so concerned about control that he would not perspective-take or see the consequences of his behaviour.

However, Eames JA found that several of Professor Kyrios' views were incautiously expressed but accepted the opinions of all three experts who testified that the offender's ability to respond appropriately to the aggravation of his child's crying was compromised by his combination of medical conditions and reduced his prison sentence accordingly – to eight years with a minimum of five years.

Psychotic symptoms associated with OCD

As noted above, OCD frequently overlaps with other mental disorders. Sometimes these can be psychotic disorders.

In *R v Ozipko*,[81] Schwann J of the Court of Queen's Bench for Saskatchewan was required to rule on whether Ronald Ozipko, aged 43, was criminally responsible for a series of apparently motiveless attacks with a knife, one of which caused death. He was charged with one count of second-degree murder and two counts of attempted murder. Ozipko had no significant criminal law history but commenced to hear voices. On the relevant night he believed his suite had been invaded by an evil spirit as a result of his decision to watch the film 'The Texas Chainsaw Massacre' repeatedly and a decision he had made as a boy not to attend a Christian school.

Ozipko was assessed by a forensic psychiatrist, Dr Lohrasbe. He was found to be able to engage in realistic discussion about everyday events without manifesting overt thought

disorder but he displayed abnormal thinking when he spoke about experiences of a spiritual or supernatural dimension – this was evidenced by disjointed speech and unravelling of logical connections. Ozipko described auditory and visual hallucinations. Dr Lohrasbe observed Ozipko to be preoccupied with the sequencing of letters, especially 'Z' and 'K', and that he identified an ominous piecing together of these letters for evil purposes. Ozipko described to Dr Lohrasbe both obsessive and compulsive symptoms, dating from childhood, such as repeated hand-washing and checking for locked doors.

Dr Lohrasbe concluded that it was highly likely that Ozipko had a schizotypal personality disorder as a prelude to schizophrenia: 'Exhibited behavior is viewed as different, odd and eccentric. The person is a misfit. From the inside, the person has odd experiences. A person with this disorder has difficulty functioning in life including work, family and relationships'.[82] He also formed the view that Ozipko suffered from OCD. In his opinion, Ozipko's preoccupations had an obsessive quality, with his violent conduct being a culmination of several influences: pre-existing schizotypal personality disorder, the impact of sleeplessness and the onset of acute psychotic symptoms with 'horrific compulsions'. In Dr Lohrasbe's opinion, Ozipko's combined mental disorder undermined his ability and capacity to believe he had a choice; he was compelled to do what he did and lacked the capacity at that time to know that his actions were morally wrong.[83]

Schwann J accepted that Ozipko was suffering from a mental disorder at the time of his offending which deprived him of the capacity to make a rational choice about whether his actions were right or wrong and meant he did not have the capacity to appreciate the nature and consequences of his actions or to refrain from acting. Thus he found him not to be criminally responsible. While OCD played a part in his deficits, it is important to identify that it was only one of a suite of mental disorders suffered by Ozipko.

A case with some comparable features to that involving Ozipko is the decision of the Kerala High Court in India in *Kumar v The State of Kerala*.[84] Kumar appealed against convictions for the assault and murder of his wife. He had previously suffered a head injury when working in Sharjah. On being taken into custody, the appellant displayed multiple obsessions, characterised by blasphemous thoughts and compulsive praying rituals. With medication, his obsessive symptomatology reduced. He was also diagnosed with bipolar disorder and hypothyroidism and was prescribed a mood stabiliser and antipsychotic medications. The appellate court concluded that Kumar was suffering from serious mental illness, including OCD, at the time of his assaults and found that by reason of unsoundness of mind he had been incapable of knowing the nature of his conduct or that it was contrary to law. However, again, the offender's OCD was only a part of his impairing mental disorders.

Sex crimes

As long ago as 1979, Reese asserted that: 'Many crimes which appear to be sexually related originate in obsessive-compulsive behaviour'.[85] In addition, while it is well recognised that there is a large over-representation of persons with personality disorders among sex-offenders,[86] a number of studies have also found a high prevalence of OCPD amongst sex offenders.[87] Generally, though, courts have not been particularly receptive to the argument that criminal offending in the form of sex offending is excused or mitigated by either OCD or OCPD. In fact, if such offending is regarded as driven by obsessions that have not been effectively addressed by treatment, this can constitute a risk factor for ongoing protection of the community – it constitutes a risk factor for recidivism.

There have been occasions too where it has been argued that OCD is relevant to whether a court should make a detention or

supervision order in relation to a convicted sex offender.[88] There is the potential for intrusive thoughts associated with pedophilia or for obsessive ideation in relation to many categories of potential victim to be serious risk factors for recidivism.[89]

Fire-setting

OCD and OCPD are disorders that have been found in some instances to be associated with fire-setting.[90] This is reflected in a number of court decisions. For instance, in *R v Johnson*,[91] the Queensland Court of Appeal heard an appeal from a sentence of four years' imprisonment, with 15 months to serve, imposed upon a woman who pleaded guilty to arson of a dwelling house. She had chronic symptoms of OCD. At the time of her offending, she had also drunk a six-pack of beer, taken sleeping tablets and was affected by cannabis. Her conduct was described by the sentencing judge as 'vindictive and selfish' but her psychological condition, which contributed to her consumption of alcohol and marijuana, was regarded to some degree as mitigating. The Court of Appeal did not interfere with the sentence imposed at first instance.

Similarly, in *R v Marson-Wood*,[92] Peters J of the New Zealand High Court had occasion to sentence a man who at the age of 19 lit some 31 different fires, to the considerable endangerment of the community. A forensic psychiatrist informed the Court that Marson-Wood had OCD, ADHD and autism, as well as a history of anxiety and depression. Ultimately Peters J stated that he reduced the custodial sentence he would otherwise have imposed by 25% for the various psychiatric disorders suffered by Marson-Wood, as well as his youth, resulting in a jail sentence of three years' imprisonment.

Harassment/stalking

Unsurprisingly,[93] some persons with OCD engage in harassment and/or stalking. Meloy has argued that there is the convergence of five psychosocial factors in stalking: social incompetence, isolation and loneliness, obsessional thinking, pathological narcissism and aggression.[94] An example was Benjamin Lewis, who was convicted of harassment of a local vicar in Southampton, England. It was alleged that he was a Satanist and had also been involved in the desecration of graves in the local cemetery. He was given only a short custodial sentence after it was established that he suffered from OCD.[95]

By contrast, in *State v Mukesh*,[96] a case involving attempted rape and attempted murder of a 22-year-old woman (counts on which he was found not guilty), as well as assaults upon her, wrongfully restraining her and following her against her will, the Delhi District Court observed:

> During the trial of the case this Court has had an occasion of actually observing the behaviour of the convict Mukesh. He appears to be having a mental fixation for the prosecutrix and is obsessed with his past relationship with her (actual or assumed) and despite being made aware that his behaviour is distressing, unwanted and objectionable to the prosecutrix (in view of her repeated previous complaints to the police), he is not ready to relent. It is in this background that observing his compulsive obsessive behaviour resulting into disbalanced conduct, the possibility of the convict Mukesh repeating his conduct with the prosecutrix (who stands a potential risk in case of his immediate release) and perhaps with more vengeance, cannot be ruled out.

For this reason the Court imposed a series of custodial sentences upon Mukesh.

Child pornography possession

Courts have been variable in their receptiveness to OCD being classified as a mitigating factor for offences involving the possession of child exploitation material.

The high point of preparedness to incorporate OCD as a mitigating factor in such offending is the Queensland Court of Appeal

decision in *R v Grehan*,[97] where Holmes, Muir and Chesterman JJA heard an appeal from the imposition of a sentence of imprisonment of three years and one day, with 18 months to serve, for Grehan possessing over 44,000 images of child exploitation (CE) material, 36 videos and 36 cartoon images. Most of the images depicted pre-pubescent children. When interviewed about his conduct, he told police he had been collecting the material for five or six years and had paid to download some of it. He said that he had tried to stop viewing and collecting about two years earlier and had erased material from the hard drive of the computers, but felt compelled to renew his activity and did so.

Expert evidence was adduced at sentencing that Grehan had OCD that had existed since he was a child, as well as marked depression and anxiety. A psychologist's report asserted of Mr Grehan that:

> He appeared to be overwhelmingly preoccupied with details and routines. He is unable to curtail repeated obsessional thoughts and compulsive behaviours. … (He) presented with depressogenic and catastrophic cognitions, extremely low self esteem and depressed mood. He possesses low self confidence, ineffective coping strategies and a sense of lifelong personal failure.
>
> (The applicant's) offending behaviour was maintained by his obsessiveness and ritualistic behaviours. He did not attribute his offending behaviours to his mental illness although the act of collecting and masturbation were perpetuated by the clinical features of obsessive compulsive disorder. Moreover, he possessed erroneous cognitions about his own sexuality and experienced persistent feelings of inadequacy and depression in response to sexual dysfunction and abnormal socio-sexual development.

The psychologist contended that Grehan presented with insight into the seriousness of his actions and appeared motivated to continue to address his deviant behaviour and thought processes. The Court of Appeal observed that:

> It is a common feature in cases of possessing CE material that the offender has much the same defects in personality as this applicant has. The inability to make and sustain normal adult relationships, particularly intimate relationships, lack of self confidence, low self esteem, anxiety, depression and isolation seem to be attributes associated with this particular offence. What distinguishes the applicant from such similar cases is the fact that he has a psychiatric disorder of such severity as to amount to a mental illness.
>
> The number of images collected and stored by the applicant is vast. Moreover they were collected over a period of about three years. There was, to that extent, some persistence in the offending. On the other hand there can be no doubt that it was the compulsive obsessive psychiatric disorder which led to the persistence in the collection over that time. The images were, it will be remembered, not looked at after their initial collection and storage.[98]

The Court determined the sentence imposed at first instance to be excessive, observing that: 'it must be remembered that the scale of offending was the product, at least in part, of the applicant's mental illness'.[99] The Court also noted that:

> Moreover the applicant had already made a commitment to psychiatric treatment and psychological counselling to address his disorders and shortcomings. The need for parole supervision was not, therefore, obvious. The applicant had formed what appears to have been a stable and supportive relationship with a woman in recent years and had taken up residence with her. This appears a positive aspect of rehabilitation, given the applicant's past isolation, and what it led to.
>
> It is also a relevant consideration that the applicant's psychiatric illness and personality inadequacies will make prison for him considerably more difficult than for the ordinary prisoner. This is not a

> factor which received any recognition, as it should have.[100]

This combination of factors led the Court of Appeal to reduce the sentence imposed.

OCD resulting in hoarding

Hoarding disorder was incorporated in DSM-5 as one of a number of obsessive-compulsive and related disorders, replacing its conceptualisation in extreme forms as a sub-set of OCD. However, it can form part of the symptoms of OCD itself.

In *Evans v The Queen*,[101] the Court of Appeal of England and Wales heard a sentencing appeal from the Crown Court at Snaresbrook in relation to the imposition of five years' imprisonment on counts of possession of multiple firearms and a considerable amount of ammunition. Evans had been employed as a civilian station reception officer at Dagenham Police Station. His main role was to deal with members of the public and included taking into police possession items of property handed in. He was aged 55 and previously of good character. He was a genuine gun enthusiast and his collection had been built up over a long period of time. His gun club had supplied a reference and other referees spoke of him as a good neighbour, family man and citizen.

At sentencing, a report from a chartered clinical psychologist noted that Evans' daughter had reported signs of obsessive anxiety in him for the past 20 years. On psychological testing of Evans, a severe level of OCD was identified, as well as clinically significant levels of anxiety and depression. He was also found to suffer from a deep-seated level of suspiciousness of others, not due to his arrest but due to the long-term effects of unresolved issues in relation to safety concerns. The psychologist offered the opinion that:

> These tests confirm his obsessive need to hoard goods in general but more specifically they confirm a need to hoard goods that represent security, such as guns and ammunition. The results also confirm obsessive safety needs in community and explain his obsessive concerns for self-defence and community awareness/ prevention of crime.[102]

Because of the relevant statutory provision, Evans could only be sentenced to less than five years' imprisonment if he proved exceptional circumstances. Neither the sentencing judge nor the Court of Appeal found such circumstances to exist in spite of his condition:

> The appellant knew what he was doing and knew that what he was doing was wrong. He retained the prohibited weapon with that knowledge. The intervention of a specialist firearms team was required to find the weapon in his house. In the context of a statute intended to protect the public from the possible consequences of unlawful possession of firearms, evidence, in an intelligent man well aware of the public issues involved, of feelings of compulsion to obtain and store guns, does not amount to exceptional circumstances.
>
> Even had exceptional circumstances relating to the offender been established, we would have considered an overall sentence in the region of five years to be required. The appellant was employed by the police force in a position of responsibility and he used that position to steal ammunition. A serious breach of trust was involved. The quantity, range and type of weapon and ammunition in his possession, together with the manner and length of time of that possession, required a severe sentence. Deterrence was a relevant factor in sentencing. Notwithstanding the substantial mitigating factors, an overall sentence in the region of five years would have been appropriate even had the appellant's obsession amounted to an exceptional circumstance.[103]

Thus, his demonstrated symptomatology of OCD afforded him little assistance on the issue of sentencing.

By contrast, though, in *Attorney-General v Golding*,[104] Commissioner Hannon had cause to sentence a 61-year-old woman who had stolen £12,741.24 from a grocery store where she worked on the till. A search of her flat revealed that she had spent all the stolen money on clothes and toiletries that she hoarded unused in her bedroom. Reports placed before the court established that she suffered from OCD. For this reason, rather than being sentenced to imprisonment, she was sentenced to a community service order. In part the critical point of differentiation was the proven extent of the offender's compulsions flowing from her obsessions and thus her reduced level of moral culpability. In part the critical point of differentiation was the proven extent of the offender's compulsions flowing from her obsessions and thus her reduced level of moral culpability.

Burden of imprisonment

The serving of a custodial sentence is likely to be experienced as especially burdensome by a person with OCD or with OCPD. It may also exacerbate the symptomatology of the condition. These considerations were explicitly recognised as relevant to the imposition of a period of incarceration by the Victorian Court of Appeal in *R v Verdins*.[105] This fact was explicitly incorporated by Eames JA in *R v D'Aloisio* into the period of imprisonment imposed on an offender with OCD, OCPD and depression.[106] It also has the potential to be relevant to the question of bail.[107]

Compliance with time limits to appeal

In *DPP v PC*,[108] the Irish Court of Appeal was required to consider an application for leave to appeal PC's conviction and sentence out of time on 60 counts of sexually assaulting his daughter and 14 counts of raping her. One of his appeal grounds related to his having OCPD and thereby being open to suggestion and suffering from memory impairment. It was also argued that PC's OPCD provided an acceptable explanation for his failure to deny the allegations made by his daughter at trial. An impediment to his pursuing his appeal was that it had been filed significantly out of time.

In a report provided to the Court of Appeal, a psychologist offered the opinion that PC met the criteria for OCPD:

> A pervasive pattern of pre-occupation with orderliness, perfectionism and mental and inter personal control at the expense of flexibility and openness (DSM/5 301.4 PG 678). He is often preoccupied with details, order and organisation and excessively devoted to work at the exclusion of leisure activities and friendships and in the past this manifested as an obsession with the game of soccer. He also has very strong views about right and wrong accounting for his need to protect his daughter above his own interests. Mr. C can show rigidness and stubbornness holding a view no matter what others try to suggest and may be reluctant to delegate tasks as he believes that he does things better. These traits have been evidenced during police interviewing whereby he refused to deny his daughter's allegations.
>
> Currently Mr C is vulnerable to a tendency to ruminate about his past and worry about his future. However he has no major mental disorder and stated that when feeling low he overcomes his feelings through strict routine and when beginning to ruminate to push his thoughts away and change perspective.[109]

The Court of Appeal described the psychologist's report as 'of extremely limited' assistance[110] but permitted the extension of time.

Concluding observations

It is apparent both from the summary of the clinical profiles of OCD and OCPD and the legal judgments, most of them appellate, to which reference has been made in this article, that the conditions have the potential to be of relevance to the criminal justice process. This article constitutes an early attempt to delineate

a number of the ways in which that relevance may be manifested. It is important not just that courts be informed that an accused person or an offender has OCD or OCPD but how it is asserted that the disorder was relevant to the commission of the criminal conduct before the court. Occasionally OCD or OCPD will be relevant to the suitability of a person to be criminally interviewed by police and to the admissibility of any admissions or confessions made. Sometimes, too, the symptomatology of OCD or OCPD may be such as to call into question an accused person's criminal responsibility. More commonly, though, OCD and OCPD may be relevant to criminal culpability at the time of sentencing, providing a context, explanation and potentially some mitigation for their blameworthiness. This can only be established by expert evidence by psychiatrists or psychologists that is not just informed by awareness of the relevant diagnostic criteria but of the nature of the person's symptomatology, its severity and how it impacted upon the conduct engaged in by the offender. OCD and OCPD have the potential to make a person highly vulnerable in a custodial environment, and there is the potential for the disorders to be aggravated by the unpredictable pressures of congregate living within a prison. Both of these issues can be relevant for sentencing and can be suitable topics for expert opinions in forensic reports and testimony.

OCD and OCPD frequently co-exist as comorbidities with other conditions, including autism spectrum disorder, ADHD and Tourette's, but also anxiety and depressive disorders. Disentanglement but also evaluation of the overall impact of the disorders can be very important.

While there is some level of public awareness of OCD, the extent of its potential relentlessness and impairment with functioning is not so well appreciated.[111] It is likely that this is mirrored in the legal environment. There is a need for a combination of ongoing legal education, including judicial education, about both OCD and OCPD, in the context of their common comorbidities, and the provision of educative, as necessary counter-intuitive and case-specific expert evidence by relevantly experienced forensic mental health practitioners with particular knowledge about the disorders.

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Ethical standards

Declaration of conflicts of interest

Ian Freckelton, QC has declared no conflicts of interest.

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Notes

1. See, eg, C Purdon, 'Assessing Comorbidity, Insight, Family and Functioning' in G Steketee (ed) *The Oxford Handbook of Obsessive Compulsive and Spectrum Disorders* (OUP, New York 2012).
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4. See, eg, P Sahoo, RR Sethy and D Ram, 'Functional Impairment and Quality of Life in Patients with Obsessive Compulsive Disorder' (2017) 39(6) Indian Journal of Psychological Medicine 760; GP Gururaj and others, 'Family Burden, Quality of Life and Disability in Obsessive Compulsive Disorder: An Indian Perspective' (2008) 54 Journal of Postgraduate Medicine 91. Bobes and others found that OCD in the Spanish population was associated with worse quality of life than for any other patient group (including physical groups), except for patients with schizophrenia: see J Bobes and others, 'Quality of Life and Disability in Patients with Obsessive-Compulsive Disorder' (2001) 16 European Psychiatry 239.
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110. It observed (at [19]) that: 'This Court asks itself how can the applicant now complain about the adequacy of his original legal advice at the police station when this matter was not complained about at his trial although it is fair to say that the appellant's own evidence suggests that he felt that he had not then got adequate advice. How does one square the finding in the psychological report of suggestibility with the other finding that the applicant is not easily dissuaded from his own position? The applicant gave evidence as to why he responded to his daughter's allegations in the way he did during the garda interviews. He denied that he had sexually assaulted or raped her. There was no suggestion that the answers he gave in the course of his garda interviews were suggested to him by the gardaí. Finally it is the case that the applicant makes no complaint about his legal representation at the second trial when he was convicted on all counts on the indictment by a unanimous jury verdict'.
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